MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

February 10, 2009

MEMORANDUM

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: JOHN A. LIVERATTI, CHIEF OF COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3600 – MANAGED CARE ORGANIZATION

BACKGROUND AND EXPLANATIONS

The language has been revised in MSM Chapter 3600 so that DHCFP may designate other geographic locations as mandatory managed care areas at a future date. The 25 mile rule has been deleted from Chapter 3600 as the Division of Insurance (DOI) has exempted Medicaid and Nevada Check Up from the rule. Private Duty Nursing services were inadvertently omitted from the current MCO Contract and Chapter 3600. It has been added to this chapter as a covered service for Managed Care. Disenrollment at the request of the enrollee has been revised and a retro-cap policy has been added to Chapter 3600. Changes are effective upon approval of the public hearing.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 04/09 CHAPTER 3600 – MANAGED CARE ORGANIZATION	**MTL 24/07** CHAPTER 3600 – MANAGED CARE ORGANIZATION
Sec. 3600 Added "The mandatory Managed Care Program is currently available to Medicaid and Nevada Check Up recipients in urban Clark and Washoe counties. DHCFP may, at a future date, designate other geographical locations as mandatory managed care areas in accordance with NAC 695C.160."	
Sec. 3602.48 Added "3602.48 PRIVATE DUTY NURSING - Nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility."	
Sec. 3603.1.A.6	Deleted "and"

Sec. 3603.1.A.7
Added "and"

Sec. 3603.1.A.8
Added "8. Aged Out Foster Care (Young adults who have "aged out" of foster care)"

Sec. 3603.2
Added "The State assures individuals will have a choice of at least two HMOs in each geographic area. When fewer than two HMOs are available for choice in the geographic areas listed, the managed care program will be voluntary."

Deleted "Mandatory managed care enrollment occurs in urban Clark County and urban Washoe County for eligible Medicaid recipients and Nevada Check Up recipients."

Sec. 3603.7
Added "geographic areas designated as mandatory managed care areas."

Deleted "urban Clark County and urban Washoe County"

Sec. 3603.8
Added "PRIVATE DUTY NURSING - Private duty nursing services are included in the HMO package for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided: a. by a registered nurse or a licensed practical nurse; b. under the directions of the recipients physician; and c. at the State's option, to a recipient in one or more of the following locations: 1. his or her own home; 2. a hospital; or 3. a nursing facility. For additional information, reference MSM Chapter 900."

Sec. 3603.15.5.a
Added "Fiscal agent by mail"

Deleted "District Office"

Added "must"

Deleted "will be instructed to"

Added "The effective date of change in the HMO will be based on the monthly administrative cut off date but not later than the first day of the second month following the month in which the enrollee makes the request to disenroll."

Deleted "or he/she will be auto assigned to another HMO. An enrollee who is a voluntary enrollee will be offered the option to join another HMO, if one is available or return to the fee for service coverage plan."

Added "Nevada Check Up enrollees are required to contact the Nevada Check Up

Deleted "The DHCFP DO staff will document the basis of the enrollee's

office if they request disenrollment from the HMO and if he/she is a mandatory recipient, must select another HMO."	request to disenroll, based on the enrollee's report. The DO will also inform the enrollee of the right to pursue a grievance or appeal of action, whichever applies, with the current HMO in the event the basis for the decision to disenroll could be resolved through that process. If the enrollee chooses not to pursue a grievance or an appeal, the DO will confirm with the enrollee the effective date of change in HMO or the return to the fee-for-service coverage plan based on the monthly administrative cut off date but not later than the first day of the second month following the month in which the enrollee makes the request to disenroll. If the enrollee is to be enrolled with another HMO, the new HMO will receive electronic notification of the enrollment."
Sec. 3603.15.5.b Added "n" twice in section	
Sec. 3603.19.B	Deleted "B. 25 Mile Rule The HMO must offer every enrolled recipient a PCP or PCS located within a reasonable distance from the enrolled recipient's place of residence but in any event, the PCP or PCS shall not be more than 25 miles from the enrolled recipient's place of residence per NAC 695C.160 without the written request of the recipient."
Sec. 3603.19.B.2	Deleted "(25 Mile Rule)"
Sec. 3603.22 Added "3603.22 RETRO-CAPITATION AND CAPITATION RECONCILIATION - Capitation payments are subject to several types of error. Most often, a capitation payment error is introduced due to an inaccuracy in eligibility or enrollment status. Some errors are corrected automatically by the MMIS, others by manual financial transaction. Depending upon the nature of the error in a particular instance, capitation may be paid or recovered from the HMO. Capitation is also reconciled periodically, typically for a three-	

month period. A. Errors automatically corrected by the MMIS. The MMIS automatically adjusts up to three months of capitation for newborns when updated Welfare eligibility data for the current month also includes previously unreported eligibility. In those instances where an eligibility agent has corrected an estimated date of birth forward in time, the MMIS automatically recovers the incorrectly paid capitation. Should an error extend beyond three months, the instance must be researched and corrected manually by financial transaction. B. Errors Corrected Manually by Financial Transaction. The HMO, in order to recover unpaid capitation, is required to submit such instances on a periodic basis via the process described in the Contract (Forms and Reporting Guide). The Business Lines unit reconciles and authorizes payment of these retro-capitation payment requests on a quarterly basis with sufficient lag time (typically three months) to allow automated MMIS corrections to occur. The Business Lines unit also reconciles and authorizes capitation recovery in instances where it is discovered that capitation has been incorrectly paid. This may occur on either a periodic or per-instance basis. C. Reconciliation of Capitation Payments-The Business Lines unit determines the validity of retro-capitation requests or may use an appropriate sample for a large number of payment requests."

Sec. 3605.1

Added "(HHS)"

Deleted "(HHA)"

Added "(CM)"

Added "S"